Community Collaboration for Appropriate Emergency Department Care: Establishment of Alternate Non-Emergency Services Providers
Second Trimester Report
July 27, 2009

Introduction

This report summarizes the second three months of activity in Washington State's Community Collaboration for Appropriate Emergency Department Care grant. April, May, and June 2009 mark the first complete trimester of data collection. The first trimester (January-March 2009) contained only limited data for the month of January and could not be considered a complete trimester in terms of data collection. For comparison purposes, this report will include data from the first trimester as well as cumulative data for the first six months.

Background

In August 2008, Washington State DSHS chose four sites to receive CMS grants with which to implement two-year emergency room diversion pilot projects. DSHS contracted with the Washington Association of Community and Migrant Health Centers to co-manage the grant sites, provide technical support, collect monthly monitoring data, conduct site visits, and advocate for the health centers involved. DSHS provides contract management and technical assistance as well. Fred Connell from the University of Washington and the DSHS Research and Data Analysis division will be conducting the project evaluations.

Sites

The sites in Washington State include:

- Interfaith Community Health Center and St. Joseph Hospital in Bellingham.
- HealthPoint, Auburn and Auburn Regional Medical Center in Auburn.
- The Community Health Association of Spokane and Holy Family Hospital in Spokane.
- Lourdes Health Network, The Yakima Valley Farm Workers Clinic (Miramar), and Community Health Center La Clinica in Pasco.

Common Elements

All four sites have incorporated the following into their programs:

- 24 hour/7 day nurse triage phone line for patients.
- Extended clinic hours.
- Additional Case Managers or patient navigators.
- Educational/outreach materials to inform the public about appropriate ER use.

Second Trimester Program Highlights

- In June 2009, The Auburn HealthPoint Clinic and Auburn Regional Medical Center held a press conference to publically announce their collaboration to decrease non-emergent ER use and highlight the "Golden Ticket" program. Once a patient has been triaged and deemed non-emergent, the patient will have the option of remaining in the ER to receive treatment or taking a "Golden Ticket" to the Auburn HealthPoint Clinic. At HealthPoint the "Golden Ticket" will give them priority status to meet with the ER diversion provider in the Acute Care Clinic. Each patient who meets with this provider will also meet with a

case manager to get connected with a primary care physician, financial assistance, and any other services they might need.

- In June 2009, Lourdes Health Network collaborated with their DSHS Patient Review and Coordination (PRC) area manager and held two trainings regarding the PRC program. These trainings were presented to hospital and partner clinic staff in order to increase staff knowledge of the PRC program and high utilizers. There were discussions about steps staff in each setting can take to discourage inappropriate ER use and increase the effectiveness of the PRC and ER diversion programs within the hospital and the clinics. The trainings were very well received by staff and opened up critical dialog between the ER, the clinics, and the PRC program.
- Interfaith Community Health Center is partnered not only with St. Joseph Hospital but with the Whatcom Alliance for Healthcare Access (WAHA). WAHA is a unique organization within the grant sites, created for and dedicated to the goal of promoting access to healthcare services in Whatcom County. WAHA is supporting the collaboration between Interfaith and St. Joseph's by providing data collection assistance, "data scrubbing", and additional client support by assisting with Medicaid and Basic Health applications.
- Community Health Association of Spokane (CHAS) has employed a full-time Patient Liaison who works directly with the ER at Holy Family Hospital. During clinic hours, when faced with a non-emergent CHAS patient in the ER, hospital staff call the Patient Liaison at CHAS to refer the client directly for follow-up. They also fax a "face-sheet" containing all the necessary information for that patient. The patient liaison then makes sure the patient has an appointment scheduled and follows up with them personally regarding their ER use and services available to them.
- All sites are currently receiving regular reports from the DSHS PRC program. These reports include lists of high utilizing patients assigned to each clinic and the number of hospital and clinic visits the patient has accumulated within the designated period of time. Each site only receives information on clients already assigned to their specific clinic. Sites are using this information to flag patients for intervention should they present at the hospital or clinic.
- Near the end of the second trimester, WACMHC launched a new website. The new website includes a section devoted entirely to the ER diversion projects. It provides information on each grant site in Washington, contact information and summaries for ER diversion projects around the country, and ER diversion related articles, tools, and links. The site can be found by visiting www.wacmhc.org and selecting the "Emergency Room Diversion" option under the "Programs and Services" tab.

Second Trimester Challenges

The primary challenge from the first trimester—engaging partner sites in the diversion projects—appears to be entirely resolved at the end of the second trimester. St. Joseph's Hospital in Bellingham, recognizing the benefit the program can provide the hospital by reducing uncompensated care, has become an active partner, participating in collaborative meetings, and encouraging the group to push themselves and make the project as successful as possible. Auburn Regional Medical Center has also taken initiative and become more engaged, as evidenced by their participation in collaborative meetings and the press conference they organized to promote their collaboration with HealthPoint, Auburn. Lourdes Health Network has

been unofficially partnered with Community Health Center La Clinica since the start of the grant in September 2008. During the second trimester, La Clinica hired a new, permanent CEO and is now officially onboard with the project. Consequently, La Clinica has been able to provide a contact person to participate in meetings and MOU negotiations, and submitted monitoring data for April, May, and June 2009.

The second challenge from the first trimester, developing referral and data sharing procedures between partner sites, has carried over into second trimester. While the majority of the data is being collected at all sites, many of the tracking processes for the monitoring items remain tedious. Several of the items must be counted by hand each month. It has been difficult to coordinate data submission deadlines as each site relies on outside sources for several monitoring items (e.g. nurse triage line reports) that are not delivered consistently each month. It has been difficult establishing referral procedures and tracking mechanisms—each of the sites have struggled with concerns over HIPPA regulations and the ability to notify the partner sites of non-emergent ER patients. While this is not an issue for patients already connected to the clinics, it makes it difficult to refer high utilizers not already established at the clinic for services. These often turn out to be the people the projects could assist best—high utilizers not connected with primary care, using the emergency room for non-emergent reasons. Consequently, each site is actively working to develop ways to engage these patients without violating their HIPPA rights or alienating patients who may be suspicious of intervention. Several of the sites have turned to PRC case managers who are often the common link between hospital and clinic to encourage proper ER use. Others are working with hospital staff who are positioned to help patients engage voluntarily at the clinics. This continues to be an ongoing challenge and sites are being encouraged to share their techniques, successes, and lessons learned with each other.

A third challenge that persisted throughout the first and second trimesters is staff turn-over. St. Joseph's, Lourdes Health Network, and Auburn Regional medical center were without emergency department directors/managers for a period of time and La Clinica and Interfaith were both working with interim executive directors for much of the grant year. At the end of the second trimester, St. Joseph's and Lourdes have hired new ER managers although Auburn is still recruiting for the position. La Clinica and Interfaith have hired permanent executive directors, freeing up the point people at these sites to focus more intensely on the ER diversion projects. There are now contact persons identified for each partner at each site.

A final challenge that arose during the second trimester was the launching of the Community Health Plan of Washington (CHPW) Nurse Advice Line. The CHPW nurse line is a valuable addition to the Washington healthcare safety net and is a welcome resource for many communities. The line is intended to work in conjunction with nurse triage lines already being used by clinics throughout the state and is not intended to replace existing services. For the ER diversion projects however, this means that patients at most clinics have the option of using either one of the nurse lines or both. This has resulted in difficulty for project staff attempting to track the number of callers using triage lines. Many clinics are still establishing procedures with CHPW to receive reports on the number of patients at their clinic using the service and eliminate duplicate callers. This has impacted the ability of sites to collect accurate monitoring information for the "24/7 Consulting/Triage Line" category throughout the second trimester.

Second Trimester Activities Completed

Since April 1, 2009, the following activities have been completed:

- The 3rd Collaborative meeting was held on May 28th, 2009 in Spokane. Representatives from each site were present. Heather Zuzel from Community Health Plan of Washington also attended and provided information on the newly launched CHPW Nurse Line.
- Site visits were conducted at each of the four grant sites. Representatives from the partner site(s) were present at each visit.
- Monitoring data was collected from each site for the months of April, May, and June 2009.
- Emily Sefcik and Nancy Anderson, MD met with representatives from the Washington State Dental Association and QUALIS Health to discuss possibilities for future collaboration.

Data Summary

GENERAL INFORMATION	**1st Trimester**	**2nd Trimester**	**Total**
# of unduplicated Medicaid *medical* patients seen in participating clinics	12457	15675	28132
# of unduplicated Managed Care *medical* patients seen in participating clinics	6053	8047	14100
# of unduplicated Fee-for-Service *medical* patients seen in participating clinics	8018	8888	16906
# of unduplicated Medicaid *dental* patients seen in participating clinics	7551	8803	16354
24/7 CONSULTING/TRIAGE LINE & EXTENDED HOURS			
# of patients at participating clinic who used a consulting/triage hotline	1629	1226	2855
# of patients seen in ER after using a consulting/triage line	31	41	72
# of patients seen in participating clinic after using a consulting/triage line	257	502	759
# of patients who used extended hours at participating clinic	1863	1643	3506
REFERRAL/MEDICAL HOME			
# of patients referred from partner ER for PCP services at participating clinics	1097	1034	2131
# of referred patients seen by PCP at participating clinics	100	111	211
# of patients from participating clinic served in partner ER	634	476	1110
MEDICAID ENROLLMENT			
# of Medicaid applications submitted at partner ER	159	139	298
# of Medicaid applications submitted at participating clinic	1095	908	2003
CASE MANAGEMENT			
# of patients assigned ED Case Manager in participating ER	536	232	768

# of patients seen by CM/Patient Navigator in participating clinic	121	190	311
# of patients who received behavioral health assessment in participating clinic	362	372	734
DENTAL			
# of *dental* patients referred from partner ER to participating clinic	16	10	26
# of referred *dental* patients seen by provider at participating clinic	6	17	23
HEALTH EDUCATION/OTHER			
# of ER diversion educational materials distributed	1061	8860	9921
Other ER diversion/outreach materials distributed	3110	1220	4330

Conclusion and Areas of Focus for Third Trimester

There are no clear conclusions or patterns that can be drawn from the monitoring data at this time. Some of the categories increased during the second trimester, some decreased, and several remained consistent over the six months. Lack of conclusive data at this point can be attributed to incomplete first trimester data, improved accuracy in tracking methods during the second trimester, the addition of data from Community Health Center La Clinica and numerous other variables at each clinic.

However, this data does point to areas where further effort is needed. For example, during the first trimester 9.1% of patients referred from the emergency rooms to the partner clinics were seen by a provider at the clinic. During the second trimester this percentage increased to 10.7%. While this demonstrates positive change, there are still only a very small percentage of the referred clients making it to the clinics. We can only speculate why this is so—most of the diversion methods established at the sites are retroactive and involve staff connecting with the patient and encouraging them to come to the clinic for follow-up after they have already been treated at the hospital. It appears many people do not want to visit a clinic unless they feel their medical issue is still an urgent concern.

However, simply contacting patients for follow-up has posed a challenge. Staff frequently encounter wrong phone numbers and addresses and are unable to connect with patients to schedule clinic appointments or provide alternative resources. Furthermore, several of the sites were not able to hire the staff responsible for following up with patients seen in the ER until the second trimester. This resulted in limited intervention at several sites for much of the first and second trimesters. Sites are currently addressing all of these factors and are also considering more proactive methods of diverting patients from the ER to the clinics. The "Golden Ticket Program at Healthpoint, Auburn is one example of this. Tracking will begin in July 2009.

Moving into the third trimester, sites will continue to refine monitoring data tracking and collection methods. Each site will also be creating a strategic plan in preparation for the second year of the grant. Strategic plans will include use of funds for year two and a section focused on sustainability—how each site will maintain the project beyond the end of the grant period. Other goals for the third trimester include maximizing PRC resources and data, increasing information sharing between sites, and expanding community involvement.